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Department of Health and Family Services

Date: January 24, 2000

To: Community Based Residential Facilities
Facilities for the Developmentally Disabled
Hospitals
Licensed Adult Family Homes
Nursing Homes
Residential Care Apartment Complexes

Regional Field Operations Directors
Regional Field Operations Supervisors
Regional Office Licensing/Certification Specialists
Resource Center Pilots

From: Susan Schroeder, Director
Bureau of Quality Assurance

Charles Wilhelm, Director
Office of Strategic Finance

Required Referrals For Pre-Admission Consultation (PAC) For Residents Of Family Care Pilot Counties with Aging and Disability Resource Centers

This purpose of this memo is to provide information on the new Pre-Admission Consultation (PAC) requirements effective with 1999 Wisconsin Act 9 (enacted 10/27/99). These requirements were enacted as part of broader legislation to create a flexible new benefit to provide long-term care services for elderly people and people with disabilities, and a new system for managing these services. This legislation was developed over four years by many concerned citizens and policy experts. During the next several years, the new program will operate only in selected pilot counties.

The Family Care benefit is an entitlement for those who meet established criteria. It may be accessed only through enrollment in Care Management Organizations (CMOs) that meet requirements specified in the legislation. Replacing a variety of current programs, Family Care creates one flexible benefit to cover all kinds of long-term care, whether provided in a person's own home, in a residential facility, a nursing home or a community day setting. A CMO will be operating under a risk based pre-paid health plan contract with the Department to provide the

flexible benefit package, based on a comprehensive assessment of the person's needs and identified outcomes. CMOs will be required to offer a comprehensive choice of all provider types in their provider network to meet the needs of their enrolled members.

In the new system, Aging and Disability Resource Centers will provide broad information and assistance services to older people, people with disabilities, and their families. Resource Centers will also provide long-term care counseling, determinations of functional and financial eligibility for the Family Care benefit, assistance in enrolling in a Care Management Organization if the person chooses to do so, and eligibility determination for certain other benefits, including Medicaid.

When Aging and Disability Resource Centers become available in a pilot county, the legislation requires nursing homes, community based residential facilities, adult family homes and residential care apartment complexes to inform prospective residents about the services of a Resource Center, the Family Care benefit and the availability of functional and financial screens to determine eligibility. These facilities and hospitals also must refer to the Resource Center persons who are seeking admission and who are expected to need long-term care services for at least 90 days, unless the person has received a functional screen within the previous six months; is entering the facility only for respite care; or is an enrollee of a CMO. When a person is referred, the Resource Center is required to provide Pre-Admission Consultation and a functional and financial eligibility screen for Family Care, if appropriate. Failure by facilities to comply with these requirements subjects the facility to an administrative forfeiture. In pilot counties, these requirements replace current requirements for referral for assessments under the Community Options Program.

More comprehensive information about the new legislation is available through the Department's web site at: http://www.dhfs.state.wi.us/LTCare/index.htm

The Department will promulgate emergency administrative rules in January 2000 to implement the new Pre-Admission Consultation requirements as part of a broad rule to implement Family Care. At the same time, the Department will propose permanent administrative rules that are very similar to the emergency rules. There will be extensive public and legislative review of the proposed permanent rules before they become effective. Both the emergency rules and the permanent rules will create a new Chapter HFS 10 of the Administrative Code. Additional amendments to Chapters HFS 82, 83, 88, 89, 124, 132 and 134 of the Administrative Code will include these new requirements by cross reference to the new Chapter HFS 10.

The new Pre-Admission Consultation requirement affects certain certified, registered or licensed residential facilities and nursing homes, including intermediate care facilities for people with mental retardation and institutions for mental diseases. Hospitals and residential facilities are required to refer certain residents of pilot counties to Aging and Disability Resource Centers for Pre-Admission Consultation prior to admission.

Hospitals serving areas in which there are Resource Centers are also required to make referrals for long term care Pre-Admission Consultation prior to discharge. Individuals included in

Family Care target groups who reside in counties with Resource Centers and who are likely to require long term care services upon discharge are to be referred.

These new statutory requirements cover Adult Family Homes under s.50.033; Residential Care Apartment Complexes under s. 50.034; Community Based Residential Facilities under 50.01; nursing homes, ICFsMR and IMDs under s. 50.04; and hospitals under s. 50.36, Wisconsin Statutes (please see attached statutory language excerpts).

Only persons who are members of certain target populations must be referred. These include elderly persons (age 65 or older) or adults with physical or developmental disabilities. Referrals are not required in some circumstances (see statutory language and administrative rule excerpts attached).

The intent of the new legislation is to ensure that individuals seeking long term care have easy and timely access to full information regarding the long term care options and public funding that may be available to them. The Resource Centers in the following counties must be fully operational (i.e., accept referrals from all hospitals, nursing homes and residential facilities serving residents of their counties) by February 1, 2001: Jackson, Trempealeau, Marathon and Kenosha. The Resource Centers in the following counties have up to one year to be fully operational from the date a Care Management Organization enters into a managed care contract with the Department to provide the new Family Care benefit in the county: Fond du Lac, Milwaukee (serving only people age 60 or older), La Crosse, Portage and Richland. Managed care contracts will be signed with all of these counties between February 1, 2000 and July 1, 2000. Resource Centers will build capacity to accept referrals as outlined above. You will receive a follow-up letter specifying the date on which your facility must begin making referrals.

Implementation of the emergency rules will require the following:

1. Persons who must be referred include those who meet the following conditions:
   - Is a resident of a county where the Department has notified the hospital, nursing home or residential facility that a Resource Center is available to accept the referral.
   - Has a long term care condition that is likely to last at least 90 days.
   - Is age 65 or over, or is at least 17 years, 9 months old and has a physical or developmental disability.
   - Is not an enrollee in a Family Care CMO (Care Management Organization), a Wisconsin Partnership Program, or a Program of All-inclusive Care for the Elderly (PACE) program.
   - A functional screen for Family Care has not been completed for the person within the previous 6 months.

2. Hospitals must, prior to discharging a person who meets the above conditions, refer the person to a Resource Center.

3. Whenever a Nursing Home, Adult Family Home, Residential Care Apartment Complex, or Community Based Residential Facility provides written information, including admission

information, about the facility to individuals who meet the conditions in 1. above, the facility must:

- Provide to the individual written material about the Resource Center.
- Inform the person that prior to admission, the facility will supply a written referral to the Resource Center for pre-admission consultation.
- Inform the individual he or she can expect to be contacted by the Resource Center for Pre-Admission Consultation and the offer of a functional and financial screen.

4. The Resource Center will supply to each hospital, nursing home and residential facility the written material to be provided to individuals at the time of referral. The materials will be standardized. Resource Centers will use a template provided by the Department.

5. The Department will provide all facilities with a suggested referral form. The original is to be kept in the facility's file with a copy going to the Resource Center. If the individual chooses to reside in the facility that has made the referral to the Resource Center, the referral will be placed in the resident file upon admission. Please see the "Referral Form to Resource Center", attached. It is the Department's suggested referral form and may be used as a template form that facilities duplicate as needed. If the facility chooses not to use the suggested form, all of the data requested on the suggested form has to be given to the Resource Center in whatever written format the facility chooses with the agreement of the Resource Center. The form is also available on the Department of Health and Family Services website at the following locations:

   http://www.dhfs.state.wi.us/LTCare/index.htm

6. The effective start date of the referral process for each facility is controlled by the Department and the affected Resource Center. Each Resource Center is required to submit a Calendar Year (CY) 2000 Pre-Admission Consultation phase-in plan for approval by the Department. The Resource Centers will identify a start date for referrals from each facility commonly used by residents of the Resource Center county. Each facility identified by the Resource Center's phase-in plan will receive a letter from the Secretary of the Department regarding the date the Resource Center will have the capacity to begin receiving referrals from that particular facility. The Resource Center will establish a process for accepting written referrals in a timely way (e.g., fax, e-mail or personal collection) for each of the facilities it identified in the Pre-Admission Consultation phase-in plan submitted to the Department. The plan will identify a single point of contact for Pre-Admission Consultation within the Resource Center.

Long-term care facilities with questions should contact the Regional Field Operations Director assigned to them. Their names and phone numbers are listed below.

Southern Regional Office 3514 Memorial Drive Madison, WI 53704-1162	Phyllis Tschumper, RFOD	(608) 243-2374 FAX: (608) 243-2389
Southeastern Regional Office 819 N. 6th St., Rm. 875 Milwaukee, WI 53203-1606	Tony Oberbrunner, RFOD	(414) 227-4908 FAX: (414) 227-4139
Northeastern Regional Office 200 N. Jefferson St., Suite 211 Green Bay, WI 54301-5182	Pat Benesh, RFOD	(920) 448-5249 FAX: (920) 448-5254
Northern Regional Office 1853 N. Stevens Street, Suite B Rhinelander, WI 54501-1246	Marianne Missfeldt, RFOD	(715) 365-2802 FAX: (715) 365-2815
Western Regional Office 610 Gibson St. Eau Claire, WI 54701-3667	Joe Bronner, RFOD	(715) 836-4753 FAX: (715) 836-2535

Hospitals with questions should contact:

Deb St. Arnauld, Program and Planning Analyst, Bureau of Quality Assurance
Telephone: (608) 267-2838
Fax: (608) 267-0352
E-mail: starnda@dhfs.state.wi.us

Residential Care Apartment Complexes with questions should contact:

Otis Woods, Program Certification Unit Supervisor
Telephone: (608) 266-0120
Fax: (608) 266-5466
E-mail: woodsol@dhfs.state.wi.us

The Department contact for Family Care Pre-Admission Consultation process and Resource Center responsibilities:

Sharon Ryan, Access Specialist, Office of Strategic Finance, Center for Delivery Systems Development
Telephone: (608) 267-7378
Fax: (608) 266-5629
E-mail: ryansa@dhfs.state.wi.us

Applicable Statutory Language as created by 1999 Act 9

Certification by Secretary of DHFS

(3) DUTY OF THE SECRETARY. The secretary shall certify to each county, hospital, nursing home, community– based residential facility, adult family home and residential care apartment complex the date on which a resource center that serves the area of the county, hospital, nursing home, community–based residential facility, adult family home or residential care apartment complex is first available to provide a functional and financial screen. To facilitate phase–in of services of resource centers, the secretary may certify that the resource center is available for specified groups of eligible individuals or for specified facilities in the county.

Adult Family Home

50.033 (2r) PROVISION OF INFORMATION REQUIRED. Subject to sub. (2t), an adult family home shall, within the time period after inquiry by a prospective resident that is prescribed by the department by rule, inform the prospective resident of the services of a resource center under s. 46.283, the family care benefit under s. 46.286 and the availability of a functional and financial screen to determine the prospective resident's eligibility for the family care benefit under s. 46.286 (1).

50.033 (2s) REQUIRED REFERRAL. Subject to sub. (2t), an adult family home shall, within the time period prescribed by the department by rule, refer to a resource center under s. 46.283 a person who is seeking admission, who is at least 65 years of age or has a physical disability and whose disability or condition is expected to last at least 90 days, unless one of the following applies:

(a) for a person who has received a screen for functional eligibility under s. 46.286 (1) (a) within the previous six months, the referral under this subsection need not include performance of an additional functional screen under 46.283 (4) (g).
(b) The person is entering the adult family home only for respite care.
(c) The person is an enrollee of a care management organization.
(d) For a person who seeks admission or is about to be admitted on a private pay basis and who waives the requirement for a financial screen under s. 46.283 (4) (g), the referral under this subsection may not include performance of a financial screen under s. 46.283 (4) (g) unless the person is expected to become eligible for medical assistance within 6 months.

(2t) APPLICABILITY. Subsections (2r) and (2s) apply only if the secretary has certified under s. 46.281 (3) that a resource center is available for the adult family home and for specified groups of eligible individuals that include those persons seeking admission to or the residents of the adult family home.

Residential Care Apartment Complex

50.034 (5m) PROVISION OF INFORMATION REQUIRED. Subject to sub. (5p), a residential care apartment complex shall, within the time period after inquiry by a prospective resident that is prescribed by the department by rule, inform the prospective resident of the services of a resource center under s. 46.283, the family care benefit under s. 46.286 and the availability of a functional and financial screen to determine the prospective resident's eligibility for the family care benefit under s. 46.286 (1).

50.034 (5n) REQUIRED REFERRAL. Subject to sub. (5p), a residential care apartment complex shall, within the time period prescribed by the department by rule, refer to a resource center under s. 46.283 a person who is seeking admission, who is at least 65 years of age or has a physical disability and whose disability or condition is expected to last at least 90 days, unless one of the following applies:

(e) for a person who has received a screen for functional eligibility under s. 46.286 (1) (a) within the previous six months, the referral under this subsection need not include performance of an additional functional screen under 46.283 (4) (g).
(f) The person is entering the residential care apartment complex only for respite care.
(g) The person is an enrollee of a care management organization.
(h) For a person who seeks admission or is about to be admitted on a private pay basis and who waives the requirement for a financial screen under s. 46.283 (4) (g), the referral under this subsection may not include performance of a financial screen under s. 46.283 (4) (g) unless the person is expected to become eligible for medical assistance within 6 months.

50.034 (5p) APPLICABILITY. Subsections (5m) and (5n) apply only if the secretary has certified under s. 46.281 (3) that a resource center is available for the residential care apartment complex and for specified groups of eligible individuals that include those persons seeking admission to or the residents of the residential care apartment complex.

Community Based Residential Facility

50.035 (4m) PROVISION OF INFORMATION REQUIRED. Subject to sub. (5p), a community-based residential facility shall, within the time period after inquiry by a prospective resident that is prescribed by the department by rule, inform the prospective resident of the services of a resource center under s. 46.283, the family care benefit under s. 46.286 and the availability of a functional and financial screen to determine the prospective resident's eligibility for the family care benefit under s. 46.286 (1).

50.035 (4n) REQUIRED REFERRAL. Subject to sub. (4p), a community-based residential facility shall, within the time period prescribed by the department by rule, refer to a resource center under s. 46.283 a person who is seeking admission, who is at least 65 years of age or has a physical disability and whose disability or condition is expected to last at least 90 days, unless one of the following applies:

(i) for a person who has received a screen for functional eligibility under s. 46.286 (1) (a) within the previous six months, the referral under this subsection need not include performance of an additional functional screen under 46.283 (4) (g).
(j) The person is entering the community-based residential facility only for respite care.
(k) The person is an enrollee of a care management organization.
(l) For a person who seeks admission or is about to be admitted on a private pay basis and who waives the requirement for a financial screen under s. 46.283 (4) (g), the referral under this subsection may not include performance of a financial screen under s. 46.283 (4) (g) unless the person is expected to become eligible for medical assistance within 6 months.

50.035 (4p) APPLICABILITY. Subsections (4m) and (4n) apply only if the secretary has certified under s. 46.281 (3) that a resource center is available for the community-based residential facility and for specified groups of eligible individuals that include those persons seeking admission to or the residents of the community based residential facility.

Nursing Homes

50.40 (2g) PROVISION OF INFORMATION REQUIRED. Subject to sub. (2i), a nursing home shall, within the time period after inquiry by a prospective resident that is prescribed by the department by rule, inform the prospective resident of the services of a resource center under s. 46.283, the family care benefit under s. 46.286 and the availability of a functional and financial screen to determine the prospective resident's eligibility for the family care benefit under s. 46.286 (1).

50.40 (2h) REQUIRED REFERRAL. (a) Subject to sub. (2i) a nursing home shall, within the time period prescribed by the department by rule, refer to a resource center under s. 46.283 a person who is seeking admission, who is at least 65 years of age or has developmental disability, or physical disability and whose disability or condition is expected to last at least 90 days, unless one of the following applies:

(m) for a person who has received a screen for functional eligibility under s. 46.286 (1) (a) within the previous six months, the referral under this subsection need not include performance of an additional functional screen under 46.283 (4) (g).
(n) The person is entering the nursing home only for respite care.
(o) The person is an enrollee of a care management organization.
(p) For a person who seeks admission or is about to be admitted on a private pay basis and who waives the requirement for a financial screen under s. 46.283 (4) (g), the referral under this subsection may not include performance of a financial screen under s. 46.283 (4) (g) unless the person is expected to become eligible for medical assistance within 6 months.

50.04 (2i) Applicability. Subsections (2g) and (2h) apply only if the secretary has certified under s. 46.281 (3) that a resource center is available for the nursing home and for specified groups of eligible individuals that include those persons seeking admission to or the residents of the nursing home.

Hospitals

50.36 (2) (c) The department shall promulgate rules that require that a hospital, before discharging a patient who is aged 65 or older or who has developmental disability or physical disability and whose disability or condition requires long-term care that is expected to last at least 90 days, refer the patient to the resource center under s. 46.283. The rules specify that this requirement applies only if the secretary has certified under s. 46.281 (3) that a resource center is available for the hospital and for specified groups of eligible individuals that include persons seeking admission to or patients of the hospital.

ENFORCEMENT

Rule-making required

50.02 (2) (d) The department shall promulgate rules that prescribe the time periods and the methods of providing information specified in ss. 50.033 (2r) and (2s), 50.034 (5m) and (5n), 50.035 (4m) and (4n) and 50.04 (2g) (a) and (2h) (a).

Penalties for RCACs, CBRFs AND AFHs

Sections 50.034 (8) and 50.035 (11) of the statutes prescribe penalties for noncompliance with these requirements as follows: If the Department finds that a Residential Care Apartment Complex or Community Based Residential Facility has not complied with the requirements of this section, it may directly impose a forfeiture of not more than $500 for each violation. If the Department determines that a forfeiture should be assessed for a particular violation, the Department shall send a notice of assessment to the facility. The notice shall specify the amount of the forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the facility of the right to a hearing.

Penalties for nursing homes

S. 50.04 (2h (b) provides penalties for nursing home non-compliance as follows: Failure to comply with the requirements of s. 50.04 (2h) is a class "C" violation under s. 50.035 (4) (b) 3.

Penalties for hospitals

S. 50.38 of the Statutes provides that if the Department finds that a hospital has not complied with the requirements of this section, it may directly impose a forfeiture of not more than $500 for each violation. If the Department determines that a forfeiture should be assessed for a particular violation, the Department shall send a notice of forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the hospital of the right to a hearing.

Draft Administrative Code Provisions

SUBCHAPTER VII — ASSURING TIMELY LONG-TERM CARE CONSULTATION

HFS 10.71 Certification by secretary of availability of resource center. When the secretary determines that a resource center is prepared to receive referrals from hospitals and long-term care facilities under ss. HFS 10.72 and 10.73, he or she shall certify to each county, hospital and long-term care facility that serves residents of the geographic area served by the resource center the date on which the resource center is first available to provide pre-admission consultation and functional and financial screens for the family care benefit. To facilitate phase-in of services of resource centers, the secretary may certify that the resource center is available for a specified target population or for specified facilities in the area of the resource center. More than one certification made be made for a resource center during the time that it phases in its services.

HFS 10.72 Referral requirements for hospitals. (1) PURPOSE. This section implements s. 50.36 (2) (c), Stats., which directs the department to promulgate rules requiring hospitals to refer certain patients to a resource center and s. 50.38, Stats., which establishes penalties for hospitals that do not comply with the requirements.

(2) APPLICABILITY. This section applies to a hospital only to the extent that the secretary has certified under s. HFS 10.71 that one or more resource centers are available for referrals from the hospital of a specified target population.

(3) REQUIRED REFERRAL. Except as provided in sub. (4), prior to discharging a patient who is aged 65 or older or who has a physical or developmental disability and whose disability or condition requires long-term care that is expected to last at least 90 days, the hospital shall refer the patient to the resource center serving the county in which the person resides. At the time that the referral is made, the hospital shall provide information to the patient about resource center services and the family care benefit, as specified by the department.

(4) EXEMPTIONS. The hospital shall refer an individual in accordance with sub. (3) unless any of the following apply:

(a) The person is under the age of 17 years and 9 months.

(b) A functional screen under s. HFS 10.33 has been completed for the person within the previous 6 months.

(c) The person is an enrollee of a care management organization, a Wisconsin partnership program, or a PACE program.

(5) PENALTIES. (a) *Forfeiture*. If the department finds that a hospital has not complied with the requirements of this section, it may directly impose a forfeiture of not more than $500 for each violation. If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the hospital. The notice shall specify the amount of the forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the hospital of the right to a hearing under par. (b).

(b) *Contest and fair hearing.* A hospital may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (a), a written request for a hearing under s. 227.44, Stats., to the division of hearings and appeals in the department of administration. The hearing shall be scheduled and conducted in accordance with the requirements of s. 50.38, Stats.

Note: A hearing request should be addressed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707. Hearing requests may be delivered in person to that office at 5005 University Avenue, Room 201, Madison, WI.

(c) *Payment of forfeitures*. All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (b), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund.

HFS 10.73 Information and referral requirements for long-term care facilities. (1) PURPOSE**.** This section implements ss. 50.033 (2r) to (2t), 50.034 (5m) to (5p) and (8), 50.035 (4m) to (4p) and (11) and 50.04 (2g) to (2i), Stats., which establish requirements for adult family homes, residential care apartment complexes, community-based residential facilities and nursing homes to provide information to prospective residents and to refer certain prospective or newly admitted residents to a resource center and establish penalties for non-compliance.

(2) APPLICABILITY. Except as otherwise specified, this section applies to the following long-term care facilities: nursing homes, community-based residential facilities, adult family homes and residential care apartment complexes. This section applies to a long-term care facility only to the extent that the secretary has certified under s. HFS 10.71 that one or more resource centers are available for referrals from the facility for one or more specified target groups.

(3) PROVISION OF INFORMATION REQUIRED. Subject to sub. (2), the facility shall give written information to each prospective resident, the resident's guardian, or a representative designated by the resident with written information of the services of a resource center, the family care benefit and the availability of screening to determine the prospective resident's eligibility for the family care benefit. The facility shall provide the information at the time it first provides, in response to a request from the person or his or her representative, any written information about the facility, its services or potential admission, or at the time that it accepts an application for admission from the person, whichever is first. The written information shall be provided to the facility by the department or by the resource center that is the subject of the

information. The facility shall obtain written verification from the resident, the resident's guardian, or a representative designated by the resident, that this information was provided.

(4) REQUIRED REFERRAL. (a) Subject to sub. (2) and at the time that required information under sub. (3) is provided, a facility shall refer to the resource center serving the county in which the person resides, a person whose disability or condition is expected to last at least 90 days and who is at least 65 years of age or has a developmental or physical disability, unless any of the following applies:

1. The person is under the age of 17 years and 9 months.

2. A functional screen under s. HFS 10.33 has been completed for the person within the previous 6 months.

3. The person is seeking admission to the nursing home only for respite care.

4. The person is an enrollee of a care management organization, a Wisconsin partnership program, or a PACE program.

5. The facility has been notified that the person was referred to the resource center by another entity within the previous 30 days.

(b) If the facility admits a person without referral because the person's disability or condition is not expected to last at least 90 days, the facility shall later refer the person to the resource center if the person's disability or condition is later expected to last at least 90 days. The facility shall refer the person within three business days of determining that the person's disability or condition is likely to last longer than was expected at the time of admission.

(c) A person seeking admission or about to be admitted to a facility on a private pay basis who is referred to a resource center need not provide financial information to a resource center or county agency, unless the person is expected to be eligible for medical assistance within 6 months or unless the person wishes to apply for the family care benefit.

(5) PENALTIES FOR RCACS AND CBRFS. (a) *Forfeiture*. If the department finds that a residential care apartment complex or a community-based residential facility has not complied with the requirements of this section, it may directly impose a forfeiture of not more than $500 for each violation. If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the facility. The notice shall specify the amount of the forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the facility of the right to a hearing under par. (b).

(b) *Contest and fair hearing.* A residential care apartment complex or a community-based residential facility may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (a), a written request for a hearing under s. 227.44, Stats., to the division of hearings and appeals in the department of administration. The hearing shall be scheduled and conducted in accordance with the requirements of s. 50., Stats.

Note: A hearing request should be addressed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707. Hearing requests may be delivered in person to that office at 5005 University Avenue, Room 201, Madison, WI.

(c) *Payment of forfeitures*. All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (b), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund.

(6) PENALTIES FOR NURSING HOMES. Failure to comply with the requirements of s. 50.04 (2g) and (2h), Stats., and this section is a class "C" violation under s. 50.04 (4) (b) 3., Stats.

HFS 10.74 Requirements for resource centers. The department shall establish, through its contracts with resource centers, minimum timeliness requirements for completion of resource center duties related to responding to referrals from hospitals and long-term care facilities. These requirements shall include a requirement that the resource center initiate contact with the person who was referred or the person's designated representative as soon as practical following receipt of a request or referral for the screen or for long term care services. This initial contact is for the purpose of informing the person about the family care benefit and the availability of functional and financial eligibility screens and long-term care options consultation, and for setting an appointment to provide further consultation and to conduct the screen. The consultation provided by the resource center shall meet the requirements for long-term care options counseling under s. HFS 10.23 (2) (b) and shall be provided in conjunction with performance of the functional and financial eligibility screens or at another mutually agreed upon time.